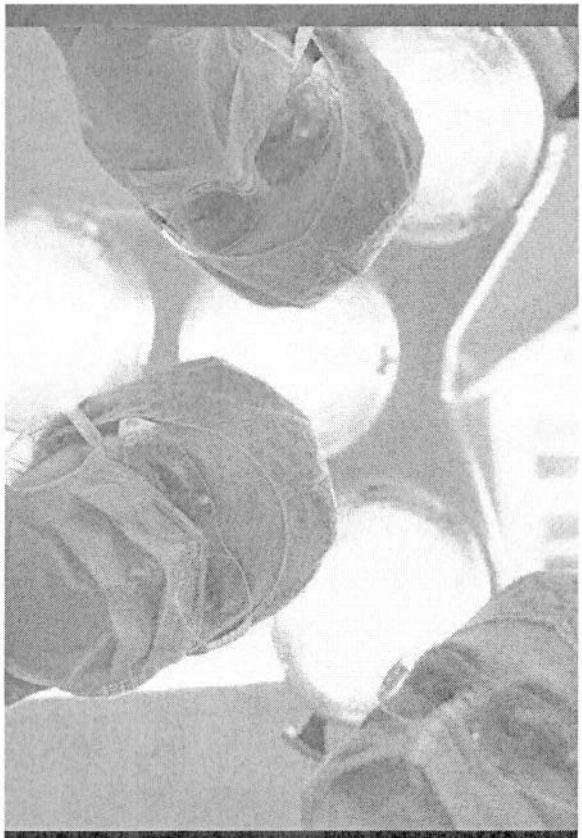
SpeakUP™



The Universal Protocol

The Joint Commission

Conduct a pre-procedure verification process

Objective To make sure that all relevant documents and related information or equipment are available before the start of the procedure and that they:

- ☐ are correctly identified and labeled
- ☐ match the patient's identifiers*
- ☐ are consistent with the patient's expectations and the team's understanding of the intended patient, procedure, and site*

Before the procedure, the health care team uses a pre-operative checklist (paper or electronic) or other medium such as a white-board to conduct the pre-procedure verification process.

Verify the availability of

- ☐ Relevant documents, such as the history and physical, pre-anesthesia assessment
- ☐ Accurate, complete, and signed procedure consent form*
- ☐ Correct and properly labeled diagnostic and radiology test results
- ☐ Any required blood products, implants, devices or special equipment

Times to verify

- ☐ When the procedure is scheduled
- ☐ When the patient is pre-admitted for testing and assessment
- ☐ When the patient is admitted to or enters the facility
- ☐ Before the patient leaves the pre-procedure area or enters the procedure room
- ☐ Anytime the patient is transferred to another caregiver during the procedure

* Whenever possible, involve the patient in these verification processes.

The team must address missing information or discrepancies before starting the procedure.

Mark the procedure site

Objective To identify without ambiguity the intended site for the procedure.

A licensed independent practitioner (or other provider who is privileged or permitted by the hospital to perform the intended procedure) marks the procedure site. This individual will also be involved directly in the procedure and will be present at the time the procedure is performed.

Mark all procedures that involve incisions, percutaneous punctures, or insertion of instruments.
Take into consideration:

- ☐ Surface
- ☐ Spine level
- ☐ Specific digit or lesion to be treated
- ☐ Laterality. For procedures involving laterality of organs but where the incision(s) or approaches may be from the mid-line or from a natural orifice, mark the site and make a note of the laterality.

The mark is made

- ☐ Before the patient is moved to the location where the procedure will be performed and with the patient involved, awake and aware, if possible.
- ☐ At or near the procedure or incision site. Other non-procedure site(s) are not marked unless necessary for some other aspect of care.
- ☐ Using the surgeon's or proceduralist's initials (preferably), with or without a line representing the proposed incision. The type of mark made should be used consistently throughout the hospital.
- ☐ Using a marker that is sufficiently permanent to remain visible after skin prep and draping. Adhesive site markers are not to be used as the sole means of marking the site.
- ☐ For spinal procedures, the mark is made in the general spinal region and the mark is made in addition to special intraoperative radiographic techniques used for marking the exact vertebral level.

Have a defined, alternative process for

- ☐ Patients who refuse site marking
- ☐ Cases in which it is technically or anatomically impossible or impractical to mark the site, such as mucosal surfaces, perineum, premature infants
- ☐ Minimal access procedures to treat a lateralized internal organ, whether percutaneous or through a natural orifice. The intended side is marked at or near the insertion site.
- ☐ Interventional procedure cases for which the catheter/instrument insertion site is not predetermined. For example, cardiac catheterization, pacemaker insertion.
- ☐ Teeth. The operative tooth name(s) and number are indicated on documentation or the operative tooth (teeth) is marked on the dental radiographs or dental diagram.

Final confirmation and verification of the site mark takes place during the time-out.

"Time out" before starting the procedure

Objective To conduct a final assessment that the correct patient, site, positioning, and procedure are identified and that all relevant documents, information, and equipment are available.

Procedural team members include: the proceduralist(s), anesthesia providers, circulating nurse, operating room technician, other active participants who will participate in the procedure when it begins.

The time-out is

- ☐ Initiated by a designated member of the procedural team
- ☐ Ideally done before the patient receives anesthesia— including general/regional, local and spinal— unless contraindicated. If not done before anesthesia administration, the time out is done before starting the procedure.
- ☐ Performed to confirm each subsequent procedure before it is initiated (when two or more procedures are being done on the same patient).

During the time-out

- ☐ Other activities are suspended, to the extent possible without compromising patient safety, so that all relevant team members are focused on the active confirmation of the correct patient, procedure, site and other critical elements of the procedure.
- ☐ All team members use interactive verbal communication. Any team member is able to express concerns about the procedure verification. If responses vary, the organization's process for reconciling differences is used.

The time-out addresses

- ☐ Correct patient identity
- ☐ Confirmation that the correct side and site are marked
- ☐ An accurate procedure consent form
- ☐ Agreement on the procedure to be done
- ☐ Correct patient position
- ☐ Relevant images and results are properly labeled and appropriately displayed
- ☐ The need to administer antibiotics or fluids for irrigation purposes
- ☐ Safety precautions based on patient history or medication use

Each organization defines a standardized procedure for the time-out, including a defined process for reconciling differences in responses.

The completed components of the Universal Protocol are clearly documented.

EXHIBIT B